Health Reimbursement Arrangement (HRA) Claim Form

Employee Name:		Date:
Employee Address (street, City, ST, Zip):		
Patient Name:	Patient Health Insurance ID #:	Relationship of Patient to Employee:
IMPORTANT NOTICE		
Any person who knowingly and with intent to defraud any benefit plan or insurance company, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.		
Reimbursement Options: Select one of the options below. ◉ Pay Medical Facility/Insurance Company Directly ◯ Reimburse Employee (proof of payment must be attached)		
I hereby authorize the Town of Grafton to either (1) make covered payments directly to the provider of services listed on the attached medical claims bill/invoice or (2) reimburse me, the employee, for the payment already remitted for the attached medical claims bill/invoice.		
Signature of Employee:		Date:

Please Note:

- Employees can only be reimbursed for (1) outpatient surgery copayments, (2) inpatient hospital admission copayments and (3) high-tech imaging scan copayments.
- Request for payment must be made within the health insurance plan/deductible year or within three months thereafter.
- Proof of payment (if applicable) and medical claims bill/invoice must be attached to receive payment. TO AVOID DELAYS IN PROCESSING, PLEASE ENSURE THE ATTACHED MEDICAL CLAIMS BILL/INVOICE INCLUDES THE FOLLOWING INFORMATION: (1) DATE OF SERVICE, (2) TYPE OF SERVICE, (3) AMOUNT CHARGED, AND (4) PATIENT'S NAME.
- Please submit claims forms to the following:

For Town Employees:

Treasurer/Collector's Office
30 Providence Rd
Grafton, MA 01519

For School Employees:

Grafton School Finance Department
30 Providence Rd
Grafton, MA 01519